Iowa Department of Human Services

Iowa State Innovation Model (SIM)
Member Engagement Workgroup
Summary of Suggestions and Discussions

The recommendations included reflect the work of the Member Engagement Workgroup and may not reflect the position of the Governor's Office and the Department of Human Services.

October 2013

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Executive Summary

The State of Iowa has been developing a State Health Care Innovation (SHIP) - the multi-year plan that ensures the State achieves its goals of lowering health care costs, improving the quality of health care for Iowans, and improving health outcomes for Iowans. Stakeholder engagement and involvement are core tenets of the State Innovation Model (SIM) grant that the State received from the Centers for Medicare and Medicaid Innovation and the State has undertaken an extensive and comprehensive approach to involving all stakeholders in the SIM design process.

In order to ensure attention and feedback on the key strategies outlined in the original grant proposal and to support the State in developing a framework for the Accountable Care Organization (ACO) model, the State developed four workgroups, one for each key strategy. These workgroups are: Metrics and Contracting; Behavioral Health Integration; Long Term Care Supports and Services Integration; and Member Engagement. All workgroup meetings were open to the public and agendas and minutes were posted to the DHS website, as were other supporting resources.

Each workgroup met four times for two hours, over the course of two months. The first meeting was primarily focused on providing information to workgroup members about the project, the context and their roles. The next three meetings were focused on discussing and developing recommendations for transforming Iowa's health care system that would be considered for inclusion in state's SHIP.

This report provides a summary of the original reference report provided to the Member Engagement Workgroup, and details about questions that were discussed in the meetings. Additionally, recommendations and suggestions generated by the Member Engagement Workgroup are included in this report.

Overview of Approach

The State of Iowa has been developing a State Health Care Innovation (SHIP) - the multi-year plan that ensures the State achieves its goals of lowering health care costs, improving the quality of health care for Iowans, and improving health outcomes for Iowans. Stakeholder engagement and involvement are core tenets of the State Innovation Model (SIM) grant that the State received from the Centers for Medicare and Medicaid Innovation and the State has undertaken an extensive and comprehensive approach to involving all stakeholders in the SIM design process.

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These workgroups are:

- *Metrics & Contracting*: Chaired by Tom Evans, this workgroup was tasked with developing recommendations and goals around the structural arrangement of the ACOs, payment provisions and metrics and measures to use.
- *Behavioral Health Integration:* Chaired by Rick Schults, this workgroup discussed measures that should be used to ensure accountability for behavioral health care needs, considerations for including the safety net providers in any ACO arrangement and the importance of building upon the strengths of the Integrated Health Home and the current Iowa Plan and its additional services and focus on recovery.
- *Long-term Care Supports and Services Integration*: Chaired by Donna Harvey, this workgroup focused on the best approach to integrating these important services into the ACO model, what care coordination should look like and what types of measures will encourage and support increased use of home and community based services.
- *Member Engagement*: Chaired by Chris Atchinson, this workgroup was tasked with developing goals and recommendations about approaches to engaging members in their own care and encouraging them to be active participants in becoming healthier. There was also discussion about how to include and incorporate the strengths of the public health system in order to address population health and achieve the Governor's Healthiest State Initiative.

Each workgroup met four times for two hours. The meetings were held every other week during the weeks of: July 22, August 5, August 19 and September 2. All workgroups had appointees but were open to the public. Meeting materials were posted on the IME SIM website, including reading materials for work group members to read before meetings, meeting agendas and meeting minutes. Although the specific areas of focus differed, the workgroup meetings were arranged as follows:

- Workgroup meeting #1: Level setting with a focus on the entire project, the need for transformation, an introduction to the ACO concept, an overview of the regional approach which will be part of the ACO model, and use of a competitive procurement process which will included multiple steps, including a Request for Information and Request for Proposals

- Workgroup meeting #2: Analysis and discussion of what works in the system of focus (LTC, BH, etc.), what does not work, and the goals and visions for a transformed system. From these workgroups, four summary documents of the key themes identified in each workgroup were developed.
- Workgroup meeting #3: Focus on developing 10 to 12 recommendations. These recommendations were then sent to the workgroups for them to identify and select their priorities. They were also asked to provide additional recommendations which might not have been mentioned. These priorities were then compiled into a summary document and shared prior to the fourth workgroup.
- Workgroup meeting #4: Focus on discussing and refining the recommendations, and soliciting any additional recommendations. Members were also asked to comment on priorities and discuss whether they would shift any of the priorities after further thought.

Prior to the first meeting, the SIM team developed a reference report for each workgroup. The Member Engagement Workgroup paper provides an overview of some current population health status and risk factor indicators, discusses State initiatives already underway, and provides an overview of approaches to member engagement used in other states. At the end of the reference report there were a series of questions that guided the discussions during workgroup meetings 2, 3 and 4.

Report Purpose

This Member Engagement Workgroup report provides a summary of the original reference report as well a summary of the workgroup discussions and suggestions. The recommendations included reflect the work of the Metrics & Contracting Workgroup and may not reflect the position of the Governor's Office and the Department of Human Services.

Overarching Principles and Goal

The Accountable Care Organization model provides an opportunity to transform Iowa Medicaid into a patient-centered system that provides more coordinated and integrated care, improves the patient experience of care, achieves better health outcomes, and reduces cost by coordinating care, providing services in the right place at the right time and reducing rates of inappropriate utilization (for example, non-emergent use of emergency rooms and avoidable hospital readmissions). IME's overall vision is to implement a multi-payer ACO methodology across Iowa's primary health care payers.

This transformation must be led by individuals becoming healthier and taking ownership of their own health and well-being. The Governor has set the goal for Iowa to become the healthiest state in the nation. To help achieve this goal he has established the Healthiest State Initiative which seeks to improve the health of individuals by encouraging active lifestyles and healthier choices. The SIM project will include elements that encourage personal responsibility for individuals to take ownership and be incented to improve their own personal health and well-being.

Current ("As Is") State

There are few incentives for people to be proactive in caring for their health and, this is true in Medicaid and for all those with private/commercial health insurance. Iowa's rates of some population health status and risk factor indicators are better or the same as the national average:

- Adult tobacco use: 20.4 percent for Iowa vs. 21.2 percent nationally
- Youth tobacco use: both 18.1 percent
- Adults reporting fair or poor health: 13.0 percent for Iowa vs. 16.9 percent nationally[1]

However, the obesity rate for adults is slightly higher than the national average (29.0 percent for Iowa vs. 27.8 percent nationally) and fewer adults report meeting not physical activity recommendations (82.8 percent for Iowa vs. 79.1 nationally). The state is particularly interested in combating obesity. Although the rate for children is below the national average, the rate of 1 in 10 children being obese is still too high. Moreover, with parents who are obese and not active, it can be difficult for children to adopt healthy diet and exercise behaviors.

These rates matter because obesity, lack of exercise and use of tobacco are all linked to the development of chronic health conditions. For example, the Centers for Disease Control and Prevention (CDC) estimates that the lifetime medical care costs for an overweight person who sustained a 10 percent weight reduction would decrease from $5,300 to $2,200, and if 10 percent of adults began a regular walking program, an estimated $5.6 million in costs associated with treating heart disease could be saved annually.[2] In Iowa, the 5 percent of people on Medicaid that have a chronic condition account for 48 percent of acute care costs.[3]

Initiatives Underway in Iowa

The Iowa Wellness Plan

The Iowa Wellness Plan contains a unique incentive program that is intended to improve the use of preventive services and other healthy behaviors through the elimination of monthly financial contributions for those who complete preventive health service requirements. Members with income exceeding 50 percent of the FPL will be required to contribute financially toward their health care costs through monthly contributions. For the first year of enrollment in the Iowa Wellness Plan, all monthly financial contributions are waived. If members complete key health improvement behaviors in their first 12 months of enrollment, the required financial contributions are waived again for the next 12-month enrollment period. The required financial contributions are the only cost sharing required of Iowa Wellness Plan members other than copayments for non-emergency use of the emergency department, which apply to all members regardless of income level but are also waived in the initial demonstration year. Key health improvement behaviors may include items such as completion of preventive health care and health assessments, and such targeted behaviors will be defined by Iowa for each coverage year. Members who continue to complete health improvement behaviors in each 12-month period of enrollment will never be subject to the required monthly financial contribution.

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[1] Iowa Department of Human Services , “Improving Iowa's Health Status “, 2012, 11.
[2] NGA Center for Best Practices, “Issue Brief: Creating Healthy States: Promoting Healthy Living in the Medicaid Program,” *NGA Center for Best Practices*, 3.
[3] Iowa DHS," Improving Iowa's Health Status", 6.

Blue Zones Project[4]

The Blue Zones Project is a community-by-community well-being improvement initiative designed to make healthy choices easier through permanent changes to environment, policy, and social networks. The focus is to lead longer lives through good health practices. There are 9 guiding practices of the Blue Zones Project (called the Power 9). To become a Blue Zones Community, a percentage of each of the six sectors (individuals, community, employers, locally-owned restaurants, public schools, grocery stores) is certified to have met certain standards/activities. Individuals pledge to take certain steps in their communities to improve their own health/lives and the government puts into place a certain percentage of the policies recommended by the Blue Zones project (smoke-free zones, etc.).

The progress of Iowan communities can be tracked online: http://www.bluezonesproject.com/communities#iowa. Currently Cedar Falls, Cedar Rapids, Mason City, Muscatine, Sioux City, Spencer and Waterloo are Blue Zones Communities. In addition, nineteen Iowa communities have been selected to receive support from experts to become Blue Zone communities; more will be selected in the future.[5]

Healthiest State Initiative

The Healthiest State Initiative is a privately led public initiative which requires partnership between the public sector, individuals, families, businesses, faith-based organizations, and not-for-profits, to improve healthy behavior within communities. This is part of Governor Branstad's goal to make Iowans healthier and happier and to ensure Iowa is the healthiest state in the nation by 2016 by the standards of the Gallup-Healthways Well-Being Index. The Index measures Daily Pulse, Life Evaluation, Emotional Health, Physical Health, Healthy Behaviors, Work Environment, and Basic Access. (http://www.well-beingindex.com/) Iowa is particularly concerned with combatting obesity, especially among children.

The Initiative's website: http://www.iowahealthieststate.com provides resources and suggestions for improving health, such as gardening at home and forming walking groups for exercise. There are also several core components such as the:

- The Healthy and Happy Outdoors (H2O) Iowa program is structured to encourage people to use outdoor space more frequently in order to improve health and reduce stress.
- The Complete Streets policy initiative is meant to improve roads for all types of users-pedestrians, motorists, and bicyclists.

The Governor's Healthiest State Initiative is aligned with the Blue Zones Project (which is being encouraged for all Iowans) by using many of the same suggestions and goals.

[4] Additional information is available at http://www.bluezonesproject.com/.
[5] Healthiest State Initiative, "Programs: Blue Zones Project™," accessed June 4, 2013, http://www.iowahealthieststate.com/blue-zones.

Other State Examples of Engaging Members and Promoting Healthy Behaviors

Healthy Indiana Plan (HIP)[6]

Summary of POWER Accounts

The Healthy Indiana Plan[7] includes Personal Wellness and Responsibility (POWER) accounts which work similarly to high deductible plans. Once the deductible is spent, the member receives comprehensive benefits, including physician visits, inpatient and outpatient services, mental health services, pharmaceuticals, labs, and other therapies, for up to $300,000 annually with a lifetime cap of $1,000,000. POWER accounts are funded through contributions made by the State and individual members. The POWER accounts also allow for employers and not-for-profits to contribute a percentage of the total. Indiana is requesting in its latest Waiver renewal application that health plans also be permitted to make contributions.

Incentivizing Proactive Health Decisions

To incentivize proactive health decisions, the State provides members with $500 for preventative services, which is used before members have to draw on their POWER accounts. If members take advantage of these funds and get certain preventative services, the State allows any unused funds in the POWER account to rollover to the next year.

Promoting Personal Responsibility

To promote personal responsibility, there are a consequences associated for members.

- If a member is more than 60 days late making a payment to his or her account, that member is expelled from the program.
- Members who use the ER for non-emergency care are charged a co-pay (currently ranging $3-$25 depending on caretaker status and FPL), which cannot be paid using the POWER account.

Relevant Program Statistics:

- 80 percent of enrollees complete the preventative services requirement for POWER account rollover.
- Over 12 months of enrollment, on average HIP enrollees show a 14.8 percent decline in use of the ER and a 25 percent increase in physician office visits.
- Approximately 90 percent of members who started eligibility in 2008 and 2009, and stayed continuously enrolled for 12 months had a physician visit of some kind. The majority of members received some preventative care during their first year of enrollment.

[6] Indiana Family and Social Services Administration, "Health Indiana Plan 1115 Waiver Extension Application," Submitted April 12, 2013.

[7] The Healthy Indiana Plan provides benefits to individuals between the ages of 19-64; who earn less than 200 percent FPL; and do not have access to employer-sponsored health insurance. It is authorized through an 1115 Demonstration Waiver that expires December 31, 2013. The State has submitted an 1115 Waiver Extension Application.

- Data from Anthem's first year (Anthem is one of the health plans providing care) shows that non-contributors are more likely to visit the ER than contributors.
- HIP members are more likely to see primary care physicians and to seek preventative care than comparable Medicaid populations.
- A survey of enrollees found that 60 percent of respondents think differently about how and where they get their healthcare since they joined the program.

Florida Medicaid Enhanced Benefit Accounts

Florida implemented a wellness program called "Enhanced Benefit Accounts," or EBA, in 2006. The State called the program a way to "broadly instill the importance of taking care of oneself"[8]. EBA participants can earn up to $125 a year by adopting behaviors and participating in credit-qualifying activities. The State determined the list of reward-eligible behaviors through review of national quality standards and analysis of claims data which identified the areas most needing improvements, such as reducing smoking rates and achieving and maintaining a healthy weight. In addition, parents can earn credits for keeping their children current with vaccinations and wellness physician visits.

There are more than 31,000 health-related products not normally covered by Medicaid that can be purchased with EBA credits. These products include: qualifying over-the-counter medications such as aspirin, cold tablets and arthritis heat wrap; non-medicinal items such as herbal remedies and vitamins; and personal hygiene items and baby care products. Disposable diapers were the most purchased item.

Survey of Members

In a telephone survey done before the program was fully implemented, 88 percent of respondents believed the incentives would help improve the health of Medicaid beneficiaries. The survey included a random sampling of Florida residents and did not ask them to identify whether or not they were Medicaid beneficiaries. Nearly three quarters of parents with children enrolled in Medicaid who had not taken their children for well-child exams previously, said they would take their children to the appointments in order to get the incentive.[9]

Use of Benchmark Benefits – West Virginia

West Virginia is one of a handful of states to use benchmark (aka alternative) benefits for its Medicaid population. The State was approved for enrollment into Mountain Health Choices in early 2007 as a pilot program. Mountain Health Choices is both an incentive based program, as members can work towards "rewards points"; and, a disincentive based program, as failure to comply with the contract requirement results in a loss of benefits such as mental health services and prescription drug coverage.

Mountain Health Choices includes a basic and "enhanced" benefit package, one for children and one for adult Medicaid beneficiaries. To qualify for enhanced benefits (which includes wellness services, nutritional education, weight management, enhanced mental health services and prescription drug coverage), members have to sign a contract promising "to do

[8] Jessica Greene, "Medicaid Efforts to Incentivize Healthy Behaviors," Resource Report. Eugene: Center for Health Care Strategies, Inc, 2007.
[9] Greene, "Medical Efforts," 3.

[their] best to stay healthy" and "to use the emergency room only in emergencies." As designed, enrollees in the enhanced benefits would have been able to earn credits in their Healthy Rewards Account (this was not fully implemented because CMS did not act upon the State's request) by participating in wellness programs, keeping appointments, etc. If enrollees opted not to sign the agreement, they would automatically be enrolled in the basic benefit program. In addition, if they fail to meet one of their member agreements, their benefits can be reduced to the "basic plan," which means reduced benefits.[10]

Evaluation

An evaluation of the program conducted in 2009, concluded that while there is widespread support for the concept and goals of the program there were serious concerns about the implementation. The key concept of personal responsibility had not lived up to its original intent since the Healthy Rewards program was not approved for implementation.[11] Following a federal rule issued April 30, 2010 that barred states from offering different benefit packages for children and from automatically enrolling adults with children into these benefit packages, Mountain Choices lost the majority of its enrollees. The State chose not to fight the regulation.

Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) [12]

As part of the ACA, CMS has provided $85 million to ten states (CA, CT, HI, MN, MT, NV, NY, NY, TX, WI) to test the effectiveness of providing incentives directly to Medicaid beneficiaries of all ages who participate in MIPCD prevention programs and change their health risks and outcomes by adopting healthy behaviors. These programs are pilots and generally target limited numbers of individuals. The grants are for five years and were awarded in the fall of 2011. The programs must use relevant evidence-based research and resources, and must address at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or improving the management of the condition. Participating States must commit to operating their program for at least 3 years and conducting a State-level evaluation. Due to the newness of the program, there is no research of its efficacy.

The programs vary in approach, though several include partnerships with public health departments, university organizations, local YMCAs and providers. Incentives include cash payments, gift cards, gym memberships, farmer's market vouchers and healthy food cookbooks. In at least one program, the provider partners receive money for providing education and making referrals. More information about each state is included as an appendix and is also available at http://innovation.cms.gov/initiatives/MIPCD/MIPCD-The-States-Awarded.html.

Shared Decision Making and Value-Based Benefit Design

Shared decision-making means the inclusion of the patient's perspective and values about treatment in collaboration with the clinician where there is no "right" course of treatment based

[10] Families USA. "Radical New Changes in Medicaid for West Virginia*,"* Washington: Families USA*,* March 2007*,* 2-3.
[11] Michael Hendryx, et al., "Evaluation of Mountain Health Choices: Implementation, Challenges, and Recommendations," *The Institute for Health Policy Research, West Virginia University* and *Mathematica Policy Research, Inc.*, March 2009.
[12] Centers for Medicare and Medicaid Services. MIPCD: The States Awarded.

on available evidence.[13] Examples of conditions that do not have one generally accepted treatment (sometimes referred to as preference-sensitive conditions (PSCs)) include low back pain, early-stage breast and prostate cancer, and hip and knee arthritis. To support the decision-making process and help the patient clarify their preferences, patients are often provided Patient Decision Aids (PDAs), or evidence-based tools that lay out the options, benefits, and risks of different medical decisions. In addition to providing the information to support shared decision making, some purchasers or programs provide financial incentives for making a specific choice or even for undergoing the process.

There is conflicting research on whether this approach saves money. A synthesis paper prepared for the Robert Wood Johnson Foundation by the American Institutes of Research reported that well-informed patients tend to choose less invasive –often less expensive – courses of treatment.[14] However, recent research by a team of researchers at the University of Chicago School of Medicine found that patients who were more involved with their medical care decisions spent 5 percent more time in the hospital and their hospital bills were $865 more, on average, than patients who were less involved.[15] The authors concluded that shared decision making is important to improving care but might not always mean lower costs.

Oregon Public Employees' Benefit Board and Educators Benefit Board Case[16]

In 2010, for its two largest employee groups, Oregon implemented value-based insurance design in its public employee health plans. The Oregon plan incorporates two types of value-based design:

- The plans increase copayments for overused or preference-sensitive services of low value; and
- The plans offer preventive and high-value services at low or no cost.

The health plan benefits are organized into three tiers:

- Tier 1 covers preventive and high-value services (i.e. medication for treating chronic disease) at low or no costs
- Tier 2 is standard and includes some cost sharing
- Tier 3 includes a separate deductible, higher out-of-pocket maximums and higher coinsurance for services that are of low-value (e.g. health services that are nationally recognized as overused and driven by provider preference or supply rather than evidence-based need, such as back surgery for pain that could be treated by physical therapy, or emergency room visits for minor illnesses).

Leveraging Public Health Expertise

As part of a focus on engaging members in their care, improving the health of all communities and individuals, public health entities – at the State and local level can play an important role. Not only do these groups provide some direct-services, most often in under-served geographic areas and also to those who have no health insurance, they also focus on the health of the

[13] American Institute for Research, " Shared Decision-Making and Benefit Design: Engaging Employees and Reducing Costs for Preference-Sensitive Conditions," April 2013.
[14] Ibid.
[15] Hyo Jung Tak, Gregory W. Ruhnke, and David O. Meltzer, "Association of Patient Preferences for Participation in Decision Making With Length of Stay and Costs Among Hospitalized Patients," JAMA Internal Medicine, 2013.
[16] G.N. Eldridge and H. Korda H, "Issue Brief. Value-Based Insurance Design: What Do We Know About What Works?" *Altarum Institute*, January 2011.

community in ways that traditional Medicaid providers don't – because the reimbursement to those providers is for the care of a single individual.

Recently, the Center for Improving Value in Health Care and the Colorado Association of Public Health Officials completed a paper, "The Role of Local Public Health Agencies in Achieving Triple Aim."[17] Although written for Colorado, the recommendations for opportunities for increased collaboration translate well for all states:

- Leveraging local public health experience in care coordination and patient navigation to support the ACA and other care coordination initiatives.
- Providing immunizations for insured individuals (assuming ability to bill private health insurers which might require support from State organizations and/or ACOs).
- Partnering with community organizations and leaders to produce long term health improvements by making healthier choices to the community (i.e. tobacco education, access to fresh foods, etc.).
- Developing referral relationships between local public health departments and primary care providers to coordinate annual screening and treatment for qualified individuals, resulting in significant cost savings, improved health status and easing the burden of an overburdened primary care system.
- Ensuring access to high quality care for vulnerable populations.
- Collecting, connecting, compiling and analyzing data to inform changes at both population-based and individual care levels.
- Performing community-health assessments to identify health needs to develop health improvement plans.

In this same document, the authors pose additional questions for the state to consider. One series relates to the role of public health entities in ACOs – the model Colorado recently implemented for the Medicaid population. Two areas of additional consideration are:

- How can public and private sectors partner to ensure local public health agencies are included in clinical information exchange? This will be essential if they are to be participants in a more coordinated delivery system.
- What type of support will public health agencies need to be connected to payment and funding mechanisms across the health system? In order for them to continue to fill-in gaps in provider shortage areas, support ACOs in behavior change activities and broaden the focus to population health they must be more aligned with the payment infrastructure.

Summary of Research and Considerations

The private sector has more options than Medicaid for creating tiered benefits, adjusting co-payment amounts, eliminating benefits, paying incentives and implementing wellness programs that are designed to engage members in their care and force them to think about their health care choices. And, many companies (roughly 50 percent according to a recent study) of these companies use or plan to use financial penalties, such as higher premiums for employees who choose not to participate in the offered programs.[18] While Medicaid programs

[17] E. Sonn, L. VanRaemdonck, and L. Wilroy, “The Role of Local Public Health Agencies in Achieving Triple Aim,” CIVHC and CALPHO, May 2013.
[18] Katherine Baicker, David Cutler, and Zurui Song. "Work Place Wellness Programs Can Generate Savings." *Health Affairs* (2010): 2304-2311.

have more restrictions, currently, more than half of the Medicaid agencies in the country are implementing or considering implementing a wellness program[19].

Despite this growth of programs that are designed to encourage members to engage and participate in their health care, little research has been done to connect wellness, incentive and penalty programs directly to decreased costs. And, experts disagree about whether the incentive ("carrot") or the penalty ("stick") is more effective in changing behaviors. But researchers and others do agree on the need for either the reward or the punishment to be as instantaneous to the desired change as possible. This makes the effect of the behavior change seem more real.[20] In fact, at the conclusion of the evaluation of Mountain Health Choices conducted by Mathematica Policy Research, this was one of the suggestions the authors made for other states to consider. They also offered the following suggestions:

- The primary goal of the program should be identified and communicated to all parties – this goal should drive program implementation (at its most basic the goal may be health improvement or cost control).
- Behavior change is best accomplished through rewards or reinforcements. Punishment or coercion are "known" to be largely ineffective in promoting positive and sustained behavior change.
- States should carefully consider the methods of rewarding positive changes in behavior. (Anecdotal information suggests that enrollees might respond better when they only have to do something once. And not all incentives used in commercial plans make sense for Medicaid enrollees, for example a gym membership might only make sense if the gym is conveniently located and provides child care.)
- States should consider operating a program on a pilot basis (many people with whom the evaluators spoke felt that West Virginia moved from a few counties to statewide too quickly). Operating on a pilot basis gives time for analyzing problems and making changes before going statewide.
- Comprehensive outreach and education efforts for enrollees and providers are critical. All enrollees need clear information.
- The State should consider what population groups are best suited for a program like Mountain Health Choices.

Workgroup Discussion Questions

Goals, Vision and Current State

1. Are there examples of member engagement strategies or examples of partnerships with public health entities in Iowa today that are working?
2. Are there specific strategies ore approaches to engaging members that are not, or have not, worked?
3. What should be the priorities or goals for the new system as it relates to member engagement?

Leveraging Existing Structure

[19] Ibid., 2304.
[20] K. Volpp, et. al. "Redesigning Employee Health Incentives – Lessons from Behavioral Economics," *New England Journal of Medicine* (2011): 388-390.

4. How should we leverage the public health system and providers to support member engagement and adoption of new and healthier behaviors?
5. Where are there solid partnerships that should be leveraged? How can these efforts translate into all communities?

Member Engagement Structure and Integration

6. Are there some populations that should not be included in an incentive or member engagement program? For example, evaluators of the West Virginia plan suggested that the approach might not be suitable for those with serious mental illness.
7. Are there specific populations that should be targeted?
8. What are the most effective incentives?
9. How can we bring this in alignment with the Blue Zones pledge and with the Governor's initiative and with member engagement strategies in the Iowa Health and Wellness Plan?
10. Do penalties ("sticks") work? If so, what types should be considered?

Financial and Measurement

11. What metrics should be used to measure whether an engagement strategy was effective?
12. What type of incentives/payments should we consider for providers to encourage patients to adopt healthy behaviors?
13. Should we consider using any of the shared savings (from the ACO model to be put in place) for building sidewalks, making more walkable communities, building bike paths, or creating community gardens in alignment with the Governor's initiative and the Blue Zones project?

Providers and Work Force Concerns

14. What type of supports will public health entities need to be able to bill/participate in an ACO arrangement? Whose job should it be to provide that support and technical assistance?
15. What type of work force issues need to be considered? Do providers need training, or do they need more partnerships and/or new types of providers in the system?
16. How can we use the health homes to provide support to people and encourage them to adopt healthy behaviors?

Workgroup Suggestions

During the third meeting, the workgroup developed a series of suggestions. The SIM team created a table of these suggestions and emailed the documents to the workgroup members; they prioritized the suggestions to support the SIM team in developing the SHIP. As part of the response to the SIM team, workgroup members also provided comments on the suggestions. To ensure each workgroup was aware of the suggestions generated by other workgroups, all four documents were sent to all the workgroup members.

This following table identifies the category of suggestion and comment; a summary of written comments and priorities received between the third and fourth Workgroup meetings, and the number r of members selecting as a priority (members ranked their top 3 suggestion). **In the final column, green boxes mean three or more people indicated as a priority; yellow boxes mean two people indicated as a priority; purple boxes mean one person indicated as a priority; and white boxes mean no member prioritized that suggestion.** It should be noted that not all workgroup members provided an indication of their priorities.

Category	#	Suggestions Captured from Workgroup Meetings	Summary of Members' Written Comments on Suggestions	Number of Members Selecting as Priority
Regulatory/ Oversight	1	The ACOs should provide the State with their patient engagement approach that demonstrates how they will support members in adopting healthy behaviors and supports providers in helping them do so. Engagement plans should be evidence-based, and and ACOs should be encouraged to partner with organizations that already develop these plans well.	The State should set forth specific outcomes and then enable ACOs through the RFP process to address how they will achieve those outcomes. If there are specific populations that require outreach, ACOs should be required to provide an outreach strategy or plan. By enabling outcomes, ACOs will be able to demonstrate programming innovation and showcase regional partnerships.	
Regulatory	2	The State should require ACOS to provide, pay for, or contract with health educators and community health workers, or participate with an	This is assumed within the ACO relationship and will vary by ACO and region.	

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		established entity for member engagement to support ACOs in being accountable for total cost of care.		
Regulatory/ Oversight	3	The contract should not be too prescriptive about how and with whom the ACOs will contract or hire to conduct member engagement.	This is encompassed and should be incorporated within #1.	
Regulatory/ Oversight	4	The State should not be prescriptive about specific partnerships that are required in an ACO arrangement.	1) A collaborative approach works best and using another entity that individuals trust beyond the ACOs may help individuals see that accessing health care is important to the entire community not just the ACO. 2) This is encompassed and should be incorporated within #1 as the ACO plan should set forth contractual relationships.	
Incentives	5	The selected incentives should have some level of immediacy in design (e.g. deferred premium payments don't work as well since it comes later). Incentives should be balanced between incentives for providers and incentives for clients.	Incentives need to be connected to preventive care or furthering of a treatment plan.	
Incentives	6	Incentive programs should recognize current healthy behaviors in addition to those who need to adopt those behaviors (e.g. non-smokers or people with normal BMI should receive the incentive).	This approach is considered the most effective in reaching the population that needs to be reached.	
Incentives	7	The state should develop patient incentives that will be universally used by all ACOs. Other people suggested that	At a minimum, the State should seek waiver authority similar to those recognized by the MSSP fraud and abuse waivers. While the State should be encourage to seek similar waiver protections for all five MSSP waiver categories (ACO Pre-Participation, ACO Participation,	

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		patient incentives could vary from ACO to ACO, providing flexibility for ACOs to develop something that works for their region.	Shared Savings Distribution, Compliance with the Physician Self-Referral Law, and Patient Incentives); for Patient Incentives, ACOs should be permitted to secure waivers for incentives that encourage preventive care and compliance with treatment regimes. The MSSP waiver language should serve as a minimum standard.	
Provider Support	8	To support ACOs in this provider training and coaching, the State (with medical centers, etc.) should develop consistent curriculum around member engagement, supporting providers in doing this, and health literacy	If considered as a recommendation, the State should consult with existing ACOs that have already made investments in this area.	
Provider Support/ Workforce Development	9	There should be a state initiative to work with community colleges and/or other technical colleges to develop programs for non-MD workforce, care coordinators, health educators, etc.		
Patient Support	10	There needs to be a form of communication that is easily understood for patients (written instruction that includes specific data elements and not too much information)		
Measures	11	As part of the Core Set of Measures, there needs to be a measurement for member engagement (this is not the same as patient satisfaction). Measures should start simple, evolve over time, align with Medicare and Wellmark	1) Partners can help with this recommendation. Also having a relationship with someone the individuals trusts can provide the support he/she needs. 2) Member engagement measure should be included and perhaps should focus on process instead of using a survey instrument.	

Category	#	Suggestions Captured from Workgroup Meetings	Summary of Members' Written Comments on Suggestions	Number of Members Selecting as Priority
		measures, and have low administrative burden on providers.		
Access	12	Primary care providers should be required to have extended hours of physician services (e.g. late evenings, weekends). At a minimum, they should have a 24 hour nurse line. There should be specific measures of access that ACOs are held accountable for, such as the length of time to get an appointment.	There should also be flexibility for rural areas and there should be allowances for telehealth solutions.	

Additional Suggestions Received Outside of Workgroup Meetings
To support ACO programming and member engagement, the State should provide upfront infrastructure payments.
I think the most important thing is to define new health care workers that will act to establish meaningful and durable relationships with patients who are the most difficult to reach/ engage
There needs to be new provider incentives
A goal of the new model should be to help encourage the development and engagement “accountable patients” as part of the solution. This means helping people see the benefits of seeing providers before they are sick, engaging in early prevention, and being part of the sytem. We may want to encourage the use of nontraditional providers, public health systems, and/or peers to help encourage people to come in for health assessments and begin to be engaged in their own health care.roup, etc.
The state should support the expansion of learning collaboratives and sharing of successes and strategies, possibly via a Transformation Center.
The ACOs should be required to develop and implement plans that will simplify care coordination for individuals.

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